

ATTACHMENT 3

CMS 1500 Claim Form instructions for clozapine management services

(For claims submitted after HIPAA implementation)

Use the following claim form completion instructions, **not** the element descriptions printed on the claim form, to avoid denial or inaccurate claim payment. Complete all required elements as appropriate. Do not include attachments unless instructed to do so.

Wisconsin Medicaid recipients receive a Medicaid identification card upon being determined eligible for Wisconsin Medicaid. Always verify a recipient's eligibility before providing nonemergency services by using the Eligibility Verification System (EVS) to determine if there are any limitations on covered services and to obtain the correct spelling of the recipient's name. Refer to the Provider Resources section of the All-Provider Handbook or the Medicaid Web site at www.dhfs.state.wi.us/medicaid/ for more information about the EVS.

Element 1 – Program Block/Claim Sort Indicator

Enter claim sort indicator "P" in the Medicaid check box for the service billed.

Element 1a – Insured's I.D. Number

Enter the recipient's 10-digit Medicaid identification number. Do not enter any other numbers or letters. Use the Medicaid identification card or the EVS to obtain the correct identification number.

Element 2 – Patient's Name

Enter the recipient's last name, first name, and middle initial. Use the EVS to obtain the correct spelling of the recipient's name. If the name or spelling of the name on the Medicaid identification card and the EVS do not match, use the spelling from the EVS.

Element 3 – Patient's Birth Date, Patient's Sex

Enter the recipient's birth date in MM/DD/YY format (e.g., February 3, 1955, would be 02/03/55) or in MM/DD/YYYY format (e.g., February 3, 1955, would be 02/03/1955). Specify whether the recipient is male or female by placing an "X" in the appropriate box.

Element 4 – Insured's Name (not required)

Element 5 – Patient's Address

Enter the complete address of the recipient's place of residence, if known.

Element 6 – Patient Relationship to Insured (not required)

Element 7 – Insured's Address (not required)

Element 8 – Patient Status (not required)

Element 9 – Other Insured's Name

Commercial health insurance must be billed prior to submitting claims to Wisconsin Medicaid, unless the service does not require commercial health insurance billing as determined by Wisconsin Medicaid.

If the EVS indicates that the recipient has dental ("DEN") insurance only or has no commercial health insurance, leave Element 9 blank.

If the EVS indicates that the recipient has Wausau Health Protection Plan (“HPP”), BlueCross & BlueShield (“BLU”), Wisconsin Physicians Service (“WPS”), Medicare Supplement (“SUP”), TriCare (“CHA”), Vision only (“VIS”), a health maintenance organization (“HMO”), or some other (“OTH”) commercial health insurance, **and** the service requires other insurance billing according to the Coordination of Benefits section of the All-Provider Handbook, then one of the following three other insurance (OI) explanation codes **must** be indicated in the **first** box of Element 9. The description is not required, nor is the policyholder, plan name, group number, etc. (Elements 9a, 9b, 9c, and 9d are not required.)

Code	Description
OI-P	PAID in part or full by commercial health insurance. In Element 29 of this claim form, indicate the amount paid by commercial health insurance to the provider or to the insured.
OI-D	DENIED by commercial health insurance or commercial HMO following submission of a correct and complete claim, or payment was applied towards the coinsurance and deductible. Do not use this code unless the claim was actually billed to the commercial health insurer.
OI-Y	YES, the recipient has commercial health insurance or commercial HMO coverage, but it was not billed for reasons including, but not limited to: <ul style="list-style-type: none"> ✓ The recipient denied coverage or will not cooperate. ✓ The provider knows the service in question is not covered by the carrier. ✓ The recipient’s commercial health insurance failed to respond to initial and follow-up claims. ✓ Benefits are not assignable or cannot get assignment. ✓ Benefits are exhausted.

Note: The provider may not use OI-D or OI-Y if the recipient is covered by a commercial HMO and the HMO denied payment because an otherwise covered service was not rendered by a designated provider. Services covered by a commercial HMO are not reimbursable by Wisconsin Medicaid except for the copayment and deductible amounts. Providers who receive a capitation payment from the commercial HMO may not bill Wisconsin Medicaid for services that are included in the capitation payment.

Element 10 — Is Patient’s Condition Related to (not required)

Element 11 — Insured’s Policy, Group, or FECA Number (not required)

Elements 12 and 13 — Authorized Person’s Signature (not required)

Element 14 — Date of Current Illness, Injury, or Pregnancy (not required)

Element 15 — If Patient Has Had Same or Similar Illness (not required)

Element 16 — Dates Patient Unable to Work in Current Occupation (not required)

Elements 17 and 17a — Name and I.D. Number of Referring Physician or Other Source (not required)

Element 18 — Hospitalization Dates Related to Current Services (not required)

Element 19 — Reserved for Local Use (not required)

Element 20 — Outside Lab? (not required)

Element 21 – Diagnosis or Nature of Illness or Injury

Enter the *International Classification of Diseases, Ninth Revision, Clinical Modification* diagnosis code (295.10-295.95) for each symptom or condition related to the services provided. List the primary diagnosis first. Etiology (“E”) and manifestation (“M”) codes may not be used as a primary diagnosis. The diagnosis description is not required.

Element 22 – Medicaid Resubmission (not required)**Element 23 – Prior Authorization Number (not required)****Element 24A – Date(s) of Service**

Enter the month, day, and year for each procedure in MM/DD/YY or MM/DD/YYYY format in the “From” field.

For recipients who have weekly white blood cell counts, clozapine management may only be billed once per week, regardless of the number of services provided during that week. For those recipients who have white blood cell counts taken every other week, clozapine management may be billed only once every two weeks.

Element 24B – Place of Service

Enter the appropriate two-digit place of service (POS) code for each service. Refer to Attachment 2 of this *Wisconsin Medicaid and BadgerCare Update* for a list of allowable POS codes for clozapine management services.

Element 24C – Type of Service (not required)**Element 24D – Procedures, Services, or Supplies**

Enter the single most appropriate five-character procedure code. Wisconsin Medicaid denies claims received without an appropriate procedure code.

Modifiers

Enter the appropriate (up to four per procedure code) modifier(s) in the "Modifier" column of Element 24D. Please note that Wisconsin Medicaid has not adopted all national modifiers.

Element 24E – Diagnosis Code

Enter the number (1, 2, 3, or 4) that corresponds to the appropriate diagnosis code listed in Element 21.

Element 24F – \$ Charges

Enter the total charge for each line item. Providers are required to bill Wisconsin Medicaid their usual and customary charge. The usual and customary charge is the provider’s charge for providing the same service to persons not entitled to Medicaid benefits.

Element 24G – Days or Units

Enter the appropriate number of units for each line item. Always use a decimal (e.g., 2.0 units).

Element 24H – EPSDT/Family Plan (not required)**Element 24I – EMG (not required)****Element 24J – COB (not required)**

Element 24K — Reserved for Local Use

Enter the eight-digit Medicaid provider number of the performing provider for each procedure if that number is different than the billing provider number in Element 33. Any other information in this element may result in claim denial.

Note: Pharmacies are not required to enter a performing provider number in this element.

Element 25 — Federal Tax I.D. Number (not required)**Element 26 — Patient's Account No. (not required)**

Optional — Providers may enter up to 20 characters of the patient's internal office account number. This number will appear on the Remittance and Status Report and/or the 835 Health Care Claim Payment/Advice transaction.

Element 27 — Accept Assignment (not required)**Element 28 — Total Charge**

Enter the total charges for this claim.

Element 29 — Amount Paid

Enter the actual amount paid by commercial health insurance. (If the dollar amount indicated in Element 29 is greater than zero, "OI-P" must be indicated in Element 9.) If the commercial health insurance denied the claim, enter "000." Do **not** enter Medicare-paid amounts in this field.

Element 30 — Balance Due

Enter the balance due as determined by subtracting the amount paid in Element 29 from the amount in Element 28.

Element 31 — Signature of Physician or Supplier

The provider or the authorized representative must sign in Element 31. The month, day, and year the form is signed must also be entered in MM/DD/YY or MM/DD/YYYY format.

Note: The signature may be a computer-printed or typed name and date or a signature stamp with the date.

Element 32 — Name and Address of Facility Where Services Were Rendered (not required)**Element 33 — Physician's, Supplier's Billing Name, Address, ZIP Code, and Phone #**

Enter the name of the provider submitting the claim and the complete mailing address. The minimum requirement is the provider's name, address, city, state, and Zip code. At the bottom of Element 33, enter the billing provider's eight-digit Medicaid provider number.